		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020925

Facility Name: North Adams Home

Address: 2259 E 1100 th Street (Number) Mendon (City) 62351 (Zip Code)

County: Adams

Telephone Number: 217-936-2137 **Fax #** 217-936-3106

IDPA ID Number: 37-0978651001

Date of Initial License for Current Owners: 10/16/1977

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 C 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Greg Sandidge Administrator **Telephone Number:** 217-936-2137

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/1/03 to 10/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Gregory A Sandidge
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) (217) 936-2137 Fax # 217-936-3106

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,894	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,894	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,703	9,588	1,960	35,251	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,703	9,588	1,960	35,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Daycare

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [ ] hallowable cost -

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/16/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 1,960

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 10/31/04 Fiscal Year: 10/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/1/03 **Ending:** 10/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	Salary/Wage	Supplies	Other	Total							
A. General Services	1	2	3	4	5	6	7	8	9	10	
Dietary	209,697	10,132	4,663	224,492		224,492		224,492			1
Food Purchase		174,554		174,554		174,554	(11,852)	162,702			2
Housekeeping	65,116	20,216	456	85,788		85,788		85,788			3
Laundry	91,669	15,323	875	107,867		107,867		107,867			4
Heat and Other Utilities			97,533	97,533		97,533		97,533			5
Maintenance	44,241	8,826	42,856	95,923		95,923		95,923			6
Other (specify):* Waste Service			10,421	10,421		10,421		10,421			7
TOTAL General Services	410,723	229,051	156,804	796,578		796,578	(11,852)	784,726			8
B. Health Care and Programs											
Medical Director			9,600	9,600		9,600		9,600			9
Nursing and Medical Records	1,466,716	65,283	18,992	1,550,991		1,550,991	(14)	1,550,977			10
Therapy		1,916	236,232	238,148		238,148		238,148			10a
Activities	67,132	6,150		73,282		73,282		73,282			11
Social Services	54,163	17		54,180		54,180		54,180			12
Nurse Aide Training		38	568	606		606		606			13
Program Transportation											14
Other (specify):*											15
TOTAL Health Care and Programs	1,588,011	73,404	265,392	1,926,807		1,926,807	(14)	1,926,793			16
C. General Administration											
Administrative	46,511			46,511		46,511		46,511			17
Directors Fees											18
Professional Services			57,685	57,685		57,685		57,685			19
Dues, Fees, Subscriptions & Promotions			18,346	18,346		18,346	(8,148)	10,198			20
Clerical & General Office Expenses	90,638	22,896	9,814	123,348		123,348	(2,882)	120,466			21
Employee Benefits & Payroll Taxes			280,113	280,113		280,113		280,113			22
Inservice Training & Education			737	737		737		737			23
Travel and Seminar			8,160	8,160		8,160	(961)	7,199			24
Other Admin. Staff Transportation			272	272		272		272			25
Insurance-Prop.Liab.Malpractice			72,275	72,275		72,275		72,275			26
Other (specify):*											27
TOTAL General Administration	137,149	22,896	447,402	607,447		607,447	(11,991)	595,456			28
TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,135,883	325,351	869,598	3,330,832		3,330,832	(23,857)	3,306,975			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number North Adams Home #0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			190,479	190,479		190,479		190,479			30
31	Amortization of Pre-Op. & Org.			4,100	4,100		4,100		4,100			31
32	Interest			124,899	124,899		124,899	(7,356)	117,543			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,600	5,600		5,600		5,600			35
36	Other (specify):* Other			10,087	10,087		10,087	(8,250)	1,837			36
37	TOTAL Ownership			335,165	335,165		335,165	(15,606)	319,559			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	7,984		5,027	13,011		13,011		13,011			38
39	Ancillary Service Centers		34,135		34,135		34,135		34,135			39
40	Barber and Beauty Shops	5,181	1,140	10,867	17,188		17,188		17,188			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,841	59,841		59,841		59,841			42
43	Other (specify):* Sales Tax			268	268		268	(268)				43
44	TOTAL Special Cost Centers	13,165	35,275	76,003	124,443		124,443	(268)	124,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,149,048	360,626	1,280,766	3,790,440		3,790,440	(39,731)	3,750,709			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,226)	2		4
5	Telephone, TV & Radio in Resident Rooms	(74)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(14)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,356)	32		10
11	Discounts, Allowances, Rebates & Refunds	(626)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(268)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(425)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,808)	21		24
25	Fund Raising, Advertising and Promotional	(4,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,291)	20		28
29	Other-Attach Schedule 5A	(9,371)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,731)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (39,731)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

North Adams Home

ID# 0020925

Report Period Beginning: 11/1/03

Ending: 10/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12	Bank Late Fees	(3,092)	36	12
13	Loan Fees	(5,158)	36	13
14	Chamber of Commerece Dues	(160)	20	14
15	Out of State Travel National Convention	(961)	24	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,371)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/1/03 **Ending:** 10/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,852)	0	0	0	0	0	0	0	0	0	0	(11,852)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,852)	0	0	0	0	0	0	0	0	0	0	(11,852)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(14)	0	0	0	0	0	0	0	0	0	0	(14)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(14)	0	0	0	0	0	0	0	0	0	0	(14)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,148)	0	0	0	0	0	0	0	0	0	0	(8,148)	20
21	Clerical & General Office Expenses	(2,882)	0	0	0	0	0	0	0	0	0	0	(2,882)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(961)	0	0	0	0	0	0	0	0	0	0	(961)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,991)	0	0	0	0	0	0	0	0	0	0	(11,991)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(23,857)	0	0	0	0	0	0	0	0	0	0	(23,857)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/1/03 **Ending:** 10/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,356)	0	0	0	0	0	0	0	0	0	0	(7,356)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(8,250)	0	0	0	0	0	0	0	0	0	0	(8,250)	36
37	**TOTAL Ownership**	(15,606)	0	0	0	0	0	0	0	0	0	0	(15,606)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(268)	0	0	0	0	0	0	0	0	0	0	(268)	43
44	**TOTAL Special Cost Centers**	(268)	0	0	0	0	0	0	0	0	0	0	(268)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,731)	0	0	0	0	0	0	0	0	0	0	(39,731)	45

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Caterpiller		x	Generator	$398.00	01/11/02	$ 12,723	$ 1,569	01/11/05	8.0000	$ 271	1
2	First Bankers Trust		x	Mortagage # 1	$17,461.00	10/23/01	1,466,855	1,118,876	02/23/11	6.2196	73,328	2
3	First Bankers Trust		x	Mortgage # 2	$3,372.00	02/24/03	530,179	508,351	02/24/06	4.5000	20,343	3
4	North Adams State Bank		x	Cash Flow Pay Off	$3,248.55	03/16/01	250,000	161,114	12/31/04	6.5000	9,923	4
5												5
	Working Capital											
6	North Adams State Bank		x	Line of Credit Cash Flow		04/08/04	125,000	125,000	04/08/05	8.0000	6,461	6
7	Elite Finance		X	AccontsReceivable Finance		12/1/04			06/03/04	Var	14,573	7
8												8
9	TOTAL Facility Related				$24,479.55		$ 2,384,757	$ 1,914,910			$ 124,899	9
	B. Non-Facility Related*											
10	Offset Int Income										(7,356)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,356)	14
15	TOTALS (line 9+line14)						$ 2,384,757	$ 1,914,910			$ 117,543	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

North Adams Home Inc. Medical Clinic 2567 SQ FT
North Adams Home Inc. Cottages 2756 SQ FT

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	435,600	1975	$ 22,893	1
2					2
3	TOTALS	435,600		$ 22,893	3

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1977	1977	$ 1,036,037	$ 25,944	40	$ 25,944	$	$ 698,751	4
5	1		1978	1978	2,633		10			2,633	5
6	10		1986	1986	438,224	14,673	30	14,673		267,040	6
7	10		1997	1977	1,374,932	34,442	40	34,442		260,057	7
8											8
	Improvement Type**										
9											9
10	PTAC Heating/AC Unit			2003	1,097	110	10	110	0	110	10
11	PTAC Heating/AC Unit			2003	965	88	10	88		88	11
12	Time Clock			2003	4,123	515	8	515		515	12
13	Compactor Electrical Wiring and Service			2003	949	79	10	79		79	13
14	Wheelchairs (6)			2003	1,150	211	5	211		211	14
15	Wheelchairs (1)			2003	794	145	5	145		145	15
16	Wheelchairs Extra Wide (1)			2003							16
17	Office Desk			2004	927	34	20	34		34	17
18	PTAC Heating/AC Unit			2004	1,097	60	15	60		60	18
19	Tables Dining Room			2004	1,799	44	10	44		44	19
20	PTAC Heating/AC Unit			2004	1,097	54	15	54		54	20
21	Geri Chair Lumber Support			2004	551	45	10	45		45	21
22											22
23	PTAC Heating/AC Unit			2004	1,097	82	10	82		82	23
24	PTAC Heating/AC Unit			2004	1,097	82	10	82		82	24
25	PTAC Heating/AC Unit			2004	1,097	73	10	73		73	25
26	Hot Water Heater Elements			2004	818	47	10	47		47	26
27	Compactor Conversion Electrical Wiring			2004	750	43	10	43		43	27
28	Water Softner Elements & Resin			2004	2,438	162	10	162		162	28
29										190	29
30	Food Processing			2004	944	55	10	55		55	30
31	Parking Lots Improvements			2004	3,869	451	5	451		451	31
32	Plumbing Replacement Drain Pipe			2004	1,000	20	25	20		20	32
33	Air Curtain			2004	578	12	15	12		12	33
34	PTAC Heating/AC Unit			2004	965	40	10	40		40	34
35	Front Office Locks			2004	613	40	10	40		40	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Front Office Locks	2004	$ 608	$ 35	10	$ 35	$	$ 35	37
38	Resident Room Glass (5)	2004	735	18	10	18		18	38
39									39
40								42	40
41	PTAC Heating/ AC Unit	2004	1,097	12	15	12		12	41
42	PTAC Heating/ AC Unit	2004	965	12	15	12		12	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,885,046	$ 77,628		$ 77,628	$ 0	$ 1,231,282	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,885,046	$ 77,628		$ 77,628	$ 0	$ 1,231,282	1
2									2
3	Generator	2002	18,497	925	20	925		2,692	3
4	Wall Panel	2002	1,829	185	10	185		538	4
5	Activity Room Flooring	2002	4,308	431	10	431		1,185	5
6	Concrete Work	2002	937	47	20	47		125	6
7	Parking Lot Light	2002	788	53	15	53		136	7
8	Room Remodel	2002	9,522	635	15	635		1,376	8
9									9
10	Roof Recoating	2001	28,450	1,897	15	1,897		6,323	10
11	Carpet Special Care Unit	2001	1,780	178	10	178		585	11
12	Concrete Work	2001	1,900	95	20	95		310	12
13	Remodel 8 Rooms	2001	11,757	784	15	784		2,417	13
14	Fencing	2001	877	88	10	88		285	14
15									15
16	Power Door SCU	2000	1,233	123	10	123		565	16
17	New Railing	2000	670	67	10	67		301	17
18	Fire Wall	2000	21,922	1,096	20	1,096		4,658	18
19	Oxygen Room	2000	2,409	120	20	120		512	19
20	Dampers	2000	2,581	172	15	172		731	20
21	Duct Detectors	2000	2,285	228	10	228		971	21
22	Emergency Lighting	2000	2,119	212	10	212		901	22
23	Smoke Fire Dampers	2000	1,300	130	10	130		542	23
24	Emergency Lighting	2000	801	80	10	80		334	24
25									25
26	Alarm System	1999	2,466	164	15	164		904	26
27	RoofRepairs	1999	11,000	733	15	733		4,033	27
28	Landscaping	1999	992	99	10	99		512	28
29	Shower Remodel	1999	2,792	141	20	141		668	29
30									30
31	Roof Repairs Reroof	1998	5,232	349	15	349		2,252	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,023,493	$ 86,660		$ 86,660	$ 0	$ 1,265,138	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,023,493	$ 86,660		$ 86,660	$ 0	$ 1,265,138	1
2									2
3	Laundry Remodel	1997	13,967	936	15	936		6,631	3
4	New addition - Egress	1997	4,431	625	10	625		3,387	4
5	New addition - Landscaping SCU Garden	1977	25,624	2,562	10	2,562		19,568	5
6									6
7	Patient Sensor System	1996	2,340	236	10	236		2,023	7
8	Landscaping	1996	776	77	10	77		638	8
9	Carpeting	1996	1,183	79	15	79		654	9
10	Ventalation	1996	1,154	77	15	77		618	10
11	Nursing Cabinets	1996	9,378	625	15	625		5,029	11
12									12
13	Staorage Room	1995	1,662	111	15	111		1,052	13
14									14
15	Patio	1994	15,076	1,254	10	1,254		15,076	15
16	Electric Doors	1994	2,867	191	15	191		1,895	16
17									17
18	Land Improvements	1993	760	6	10	6		760	18
19	Roof Repairs	1991	82,210	4,128	20	4,128		55,380	19
20	Garage	1990	31,318	1,044	30	1,044		14,702	20
21	Parking Lot Paving	1990	10,500					10,500	21
22	Parking Lot Grading	1990	1,017					1,017	22
23	Roof Repairs	1990	1,372	91	15	91		1,272	23
24									24
25	Patient Sensor System	1989	3,964						25
26	Dining room Remodel	1989	3,943	197	15	197		3,943	26
27									27
28	Wall Carpet	1988	12,374	70	15	70		12,374	28
29	Cabinet Doors	1988	5,316	266	20	266		4,319	29
30	Sprinklers	1988	663	27	25	27		431	30
31	Exhasut Fan Door Locks	1988	2,151	12	15	12		2,151	31
32	Sidewalk Sheltor Floor	1988	2,583					2,583	32
33	Land Improvements	1988	3,052					3,052	33
34	TOTAL (lines 1 thru 33)		$ 3,263,174	$ 99,274		$ 99,274	$ 0	$ 1,434,193	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,263,174	$ 99,274		$ 99,274	$ 0	$ 1,434,193	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9	Capital Improvements 1981-1987	1981	233,820	18,371		18,371		233,820	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,496,994	$ 117,645		$ 117,645	$ 0	$ 1,668,013	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 689,669	$ 70,884	$ 70,884	$	5-15	$ 389,597	71
72	Current Year Purchases	4,130	425	425		5-10	425	72
73	Fully Depreciated Assets	255,786				5-15	255,064	73
74								74
75	TOTALS	$ 949,585	$ 71,309	$ 71,309	$		$ 645,086	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1980 Ford Bus	1990	$ 45,725	$	$	$	5	$ 45,725	76
77	Patient Transport	1999 Ford Mini Bus	1999	37,900				5	37,900	77
78	Patient Transport	1998 Chevy Van	2002	7,500	1,525	1,525		5	3,559	78
79										79
80	TOTALS			$ 91,125	$ 1,525	$ 1,525	$		$ 87,184	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,560,597	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 190,479	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 190,479	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,400,283	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Medical Clinic	$ 176,944	$ 5,684	$ 131,949	86
87	Land Trust	49,865			87
88	Beauty Shop	1,234		1,234	88
89	Attached Listing	517,510	15,399	206,689	89
90					90
91	TOTALS	$ 745,553	$ 21,083	$ 339,872	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Line 90 Schedule	Cost	Current	Accumulated
Section F			
Cottage # 1	$ 75,325.00	$ 2,404.00	$ 54,302.00
Cottage Engineering	$ 13,316.00	$ 333.00	$ 3,662.00
Cottage Sewer	$ 839.00	$ 21.00	$ 193.00
Cottage Sewer	$ 24,101.00	$ 604.00	$ 6,085.00
Cottage Equip	$ 5,450.00	$ 363.00	$ 3,966.00
Land Imp	$ 6,860.00		
Land Imp	$ 6,455.00		
Cottage#2	$ 82,066.00	$ 2,672.00	$ 40,757.00
Parking Lot	$ 10,300.00		$ 10,300.00
Cottage # 2	$127,973.00	$ 4,290.00	$ 50,754.00
Alarm System	$ 1,650.00	$ 110.00	$ 1,293.00
Appliances	$ 1,159.00	$ -	$ 1,159.00
Carpet	$ 1,320.00	$ 88.00	$ 924.00
Carpet	$ 2,110.00	$ 142.00	$ 1,167.00
Carpet	$ 1,070.00	$ 73.00	$ 611.00
Carpet	$ 1,145.00	$ 77.00	$ 633.00
Shelves	$ 500.00	$ -	
Range	$ 660.00	$ -	
Refrigerator	$ 654.00	$ 131.00	$ 654.00
Cottage # 4	$137,600.00	$ 3,473.00	$ 17,451.00
Carpet	$ 1,388.00	$ 93.00	$ 471.00
Reroof Cottage # 3	$ 2,486.00	$ 166.00	$ 774.00
Refrigerator	$ 965.00	$ 122.00	$ 427.00
Chapel Equip	$ 11,023.00	$ 95.00	$ 10,405.00
Beauty Shop Remode	$ 846.00	$ 106.00	$ 529.00
Beauty Shop Equip	$ 249.00	$ 36.00	$ 172.00
	$517,510.00	$15,399.00	$ 206,689.00
		$15,399.00	$ 206,689.00
			$ -

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,600 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	99

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER AIDE	56

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 568	$	$ 568
2	Books and Supplies		38		38
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 606	$	$ 606
10	SUM OF line 9, col. 1 and 2 (e)	$ 606			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Page 3 line 10 acol 2 & 3	hrs	$	870	$ 49,617	$ 714	870	$ 50,331	1
2	Licensed Speech and Language Development Therapist	Page 3 line 10 acol 2 & 3	hrs		1,902	108,409	83	1,902	108,492	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Page 3 line 10 acol 2 & 3	hrs		1,372	78,206	1,119	1,372	79,325	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39 Col 2	# of prescrpts				34,135		34,135	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	4,144	$ 236,232	$ 36,051	4,144	$ 272,283	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (2,817)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	570,253		3
4	Supply Inventory (priced at FIFO)	32,936		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,508		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 612,880	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	104,702		12
13	Land	255,604		13
14	Buildings, at Historical Cost	3,931,176		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,090,632		16
17	Accumulated Depreciation (book methods)	(2,778,601)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	16,962		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,620,475	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,233,355	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 333,791	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	126,569		29
30	Accrued Salaries Payable	123,444		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Resident Fund Liability	1,193		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 584,997	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	669,465		39
40	Mortgage Payable	1,118,876		40
41	Bonds Payable			41
42	Deferred Compensation	175,570		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,963,911	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,548,908	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 684,447	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,233,355	$	48

***(See instructions.)**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 738,277	1	
2	Restatements (describe):		2	
3	**Audit Adjustment**	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 738,279	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(53,832)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (53,832)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 684,447	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,793,658	1
2	Discounts and Allowances for all Levels	(280,339)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,513,319	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,120	12
13	Barber and Beauty Care	19,561	13
14	Non-Patient Meals	11,240	14
15	Telephone, Television and Radio	74	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,616	19
20	Radiology and X-Ray	35	20
21	Other Medical Services		21
22	Laundry	2,412	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 45,058	23
	D. Non-Operating Revenue		
24	Contributions	110,428	24
25	Interest and Other Investment Income***	7,364	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 117,792	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Cottage Income**	21,265	28
28a	**Rental Income**	39,174	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 60,439	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,736,608	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	796,578	31
32	Health Care	1,926,201	32
33	General Administration	608,053	33
	B. Capital Expense		
34	Ownership	335,165	34
	C. Ancillary Expense		
35	Special Cost Centers	64,602	35
36	Provider Participation Fee	59,841	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,790,440	40
41	**Income before Income Taxes (line 30 minus line 40)****	(53,832)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,832)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 47,930	$ 23.04	1
2	Assistant Director of Nursing	2,175	2,296	48,268	21.02	2
3	Registered Nurses	8,865	9,104	179,985	19.77	3
4	Licensed Practical Nurses	30,531	31,586	437,114	13.84	4
5	Nurse Aides & Orderlies	58,416	63,215	622,292	9.84	5
6	Nurse Aide Trainees	6,694	6,823	53,576	7.85	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,986	5,416	56,541	10.44	8
9	Activity Director	2,004	2,102	22,547	10.73	9
10	Activity Assistants	6,394	6,750	44,584	6.61	10
11	Social Service Workers	4,160	4,336	54,163	12.49	11
12	Dietician					12
13	Food Service Supervisor	2,984	3,089	34,229	11.08	13
14	Head Cook	4,778	4,869	35,011	7.19	14
15	Cook Helpers/Assistants	10,915	11,225	68,432	6.10	15
16	Dishwashers	9,936	10,240	72,025	7.03	16
17	Maintenance Workers	3,165	4,104	44,241	10.78	17
18	Housekeepers	7,917	8,428	65,116	7.73	18
19	Laundry	10,251	10,711	91,669	8.56	19
20	Administrator	2,080	2,080	46,511	22.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,418	6,814	63,091	9.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,929	1,954	21,011	10.75	31
32	Other Health C: Transport&beut	1,580	1,610	13,165	8.18	32
33	Other(specify) Accontant	1,560	1,560	27,547	17.66	33
34	TOTAL (lines 1 - 33)	189,818	200,392	$ 2,149,048 *	$ 10.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 4,663	11 c3	35
36	Medical Director	Contract	9,600	19 C 3	36
37	Medical Records Consultant	24	1,482	110 c3	37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	192	2,891	110 c3	39
40	Physical Therapy Consultant	124	6,318	110 c3	40
41	Occupational Therapy Consultant		0		41
42	Respiratory Therapy Consultant		0		42
43	Speech Therapy Consultant		0		43
44	Activity Consultant		0		44
45	Social Service Consultant		0		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	532	$ 24,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses	192	6,696	110 c3	51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)	192	$ 6,696		53

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gregory A Sandidge	Administrator	0	$ 46,511
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 46,511

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hubert G Staff	Legal	$ 5,750
Duanne Morris	Legal	11,865
American Express	Healthcare	6,000
WDM	Data Processing	7,544
Hicks Pension Services	Pensions	2,020
Ausher Melvin Glasser	Medicare Cost Report	1,873
WDM	Medicaid Cost Report	1,500
Ivans	Software Support	555
Poeoping Stone Bach	Life Safety Code	585
EBC	Flex Administration	1,500
ABDG	Independent Audit	10,072
Other		8,421
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 57,685

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,485
Unemployment Compensation Insurance	10,714
FICA Taxes	163,541
Employee Health Insurance	20,678
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K Match	11,576
Life Insurance	5,577
Employee Physicals	2,571
Other Employee Benefits	2,971
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,113

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,123
Advertising: Employee Recruitment	2,959
Health Care Worker Background Check	788
(Indicate # of checks performed 59)	
Yellow Pages	3,291
Public Relations	4,272
Contributions	425
LSN Dues	5,328
Chamber of Commerce	160
Less: Public Relations Expense	(4,272)
Non-allowable advertising	(585)
Yellow page advertising	(3,291)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,198

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 961
Disallow out of state travel	(961)
In-State Travel	
Employee Business Travel	272
Seminar Expense	4,172
Hotels	681
Milage Parking	1,526
Meals	548
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,199

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/1/03 Ending: 10/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/1/03 **Ending:** 10/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN $5328

(3) Did the nursing home make political contributions or payments to a politica action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 12

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 21,617 Line 10 Col 2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 59,841
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 11,226 Has any meal income been offset against related costs? No Indicate the amount. $ 11,266

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. $ 7,808

c. What percent of all travel expense relates to transportation of nurses and patients? 94

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ No

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BENNET AND MIDDENDORF The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Board of Directors	Nov 1 2003 - Oct 31 2004
Ron Husemann	President
Terry Asher	Vice President
Linda Duncan	Secretary
Linda Cornwell	Treasurer
Rich Mealiff	2 nd Vice President
Dan Clair	
Gary Butler	
Sue Woodruff	
Betty Pracht	
Ann Wesbecker	
Pastor Tom Kamprath	
Janet Dickhut	
Russel Beeler	
Bernie Venverloth	

Schedule 6 E

Name of Vendor	Service	Total
Qulaicomp	Computer Support	75
ABDG	Consulting	696
Young Accounting	Consulting	2070
AccuMAx	Computer Support	5580
Total		$ 8,421.00